Health Services
LOS ANGELES COUNTY

November 30, 2016



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*To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.*

TO: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **DEPARTMENT OF HEALTH SERVICES' PERFORMANCE INDICATORS (ITEM #26 FROM THE OCTOBER 4, 2016 BOARD MEETING)**

On October 4, 2016, the Board instructed the Department of Health Services (DHS) to report back to the Board in writing on the Department's performance indicators and to present information to the Board offices detailing what is new, where the struggles are and the opportunities available for improvement.

DHS tracks and reports data on a variety of performance measures covering various areas. As examples, core clinical activities are tracked via CMS Core Measures, Star Ratings, and waiver programs; information technology use is monitored through Meaningful Use measures; patient safety is tracked per state and federal regulatory requirements, etc. The Department will continue to send periodic updates on these and other measures.

This memo will focus specifically on performance measures of specific strategic importance for the Department and where new data were recently made available, specifically the Healthcare Effectiveness Data and Information Set (HEDIS), Public Hospital Redesign and Incentives in Medi-Cal (PRIME), and The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) and the Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAHPS), outpatient primary care and inpatient patient satisfaction measures, respectively.

## Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of measures widely used by U.S. health plans to measure and compare various facets of a health system's performance. In total there are 81 HEDIS measures, though each health plan typically selects

only a subset of these for use in measuring provider performance. In addition to being used as a tool to gauge the overall quality and service levels of a particular provider, HEDIS is also commonly used to help guide the assignment of lives among and between plans. For example, in California, Geographic Managed Care and Two-Plan counties use HEDIS, as well as two safety-net related metrics, to determine which managed care plan will receive a greater proportion of "auto-assigned" or default-assigned managed Medicaid lives. HEDIS data is measured annually by each plan; the 2015 and 2014 data for DHS' performance with both LA Care and Health Net members is included in Attachment I.

While DHS' performance on many HEDIS metrics improved from 2014 to 2015, our performance is still below where we aspire to be. In part, this is a natural result of the large proportion of default-assigned lives that DHS receives as a result of AB85. Individuals who are default-assigned often don't have a strong existing relationship with a primary care provider and may be difficult to engage in regular, routing preventive and primary care services, such as what is measured in part by HEDIS. While this point is important in understanding the challenge of improving HEDIS results, DHS takes seriously its responsibility to provide for the comprehensive health care needs of all of those for whom it is responsible under Medicaid managed care. There are several initiatives in place that will help the Department continue to improve its HEDIS performance in the coming years:

*Empaneled Life Management (ELM) (i.e., HealtheIntent):*
DHS recently contracted with Cerner to acquire HealtheIntent. HealtheIntent is Cerner's integrated population health platform for patient care. DHS' instance of HealtheIntent is named "ELM" (Empaneled Life Management). ELM will allow for the attribution of empaneled lives to specific providers (i.e., the creation of panels) and the development of customized algorithms and registries to support clinical reporting across various subsets of DHS' patient population. We anticipate that the registry and empanelment functionality of ELM will be live by Summer 2017. HEDIS metrics are being built into ELM as a standard registry. Once live, this tool will allow Primary Care Medical Home (PCMH) teams, including providers, nurses, Certified Medical Assistants (CMAs), and other PCMH team members, to manage their patient panels more effectively both during and in between patient encounters.

*HEDIS Advantage Solution:*
In early 2017, DHS managers and providers will have access to a new tool to monitor progress on HEDIS metrics more closely. Through the Community Health Plan (CHP) Transition Safety Net Support Agreement with LA Care, DHS has obtained a subscription to its own version of Inovalon's "HEDIS Advantage Solution". This is the same system used by LA Care for tracking and reporting HEDIS metrics, and it will enable DHS staff to view facility- and provider-specific HEDIS quality metric results on a monthly basis, instead of waiting until the health plans produce annual report cards. Data from the new DHS Comprehensive Enterprise Data and Analytics Repository (CEDAR) will be uploaded to Inovalon on a monthly basis. This data feed will include member data from both LA Care and Health Net, as well as uninsured patients who have been empaneled to DHS providers. It will also include DHS utilization data for these members and patients, including hospitalizations, emergency room visits, outpatient clinic visits,

laboratory tests, radiology test, and pharmaceuticals dispensed. DHS users will have the ability to view the HEDIS metric results through a secure browser interface.

Together, both ELM and the HEDIS Advantage Solution will offer individual providers, medical home teams, and managers throughout DHS the ability to view their performance on HEDIS metrics in a timely manner. It will also enable them to rapidly respond to low-performing metrics, including identification of non-compliant members and the opportunity to contact members for additional services at any time during the reporting year. The expected end result is improved performance on all HEDIS metrics.

In addition to the technology solutions described above, DHS is also undertaking other initiatives that will help to improve performance on HEDIS measures. Of particular note is further development of capabilities within DHS facility Patient Access Centers (PAC) and PCMHs.

- Facility-based PACs will manage critical front-office operations for primary care clinics, including scheduling, financial screening and registration functions, as well as basic member service functions, including patient outreach calls.
- DHS is in the process of building a small Primary Care Resource Center (PCRC) which will provide key support and resources for the further development of our medical homes. Focus of the PCRC will include data and analytic support for PC teams; coaching on continuous quality/process improvement techniques; IT and informatics support; coordination of PC team recruitment needs; training, coaching, and assistance to PCMH teams; and assistance with staff and patient communications.

Finally, as a number of HEDIS measures are included in DHS' five-year PRIME plan, this will provide an additional incentive to improve performance on these particular measures. Those measures that overlap between PRIME and HEDIS are noted in Attachment I. Additional information is provided on PRIME below.

**Patient Satisfaction**

All DHS hospitals survey inpatients and primary care patients with the standardized H-CAHPS and CG-CAHPS survey questionnaire. DHS H-CAHPS and CG-CAHPS data is available in Attachment II.

DHS highly values the experience of our patients and is actively striving to improve the levels of service provided to our patients. For both CG-CAHPS and H-CAHPS, there are a variety of system- and facility-specific initiatives in place that are targeting certain areas of improvement. For H-CAHPS in particular, a few examples of these were detailed in the recent memo to the Board regarding CMS Star Rating scores and are included again for your reference below.

Improving the Hospital Environment (Cleanliness) at Harbor-UCLA Medical Center (H-UCLA): This summer, H-UCLA worked with its environmental services partner, Sodexo, to implement

an initiative to improve its HCAHPS score for cleanliness in the hospital inpatient setting. There were three major focus areas:

- Patient Rounding: Harbor initiated a "Patient Ambassador" program in which 50 patients are surveyed each day on their perception of room cleanliness. The Patient Ambassador immediately initiates service recovery to address the patient's concerns. Previously, housekeeping staff were dependent upon nursing staff to report and initiate service recovery.
- Patient Room Cleaning: Sodexo evaluated the workflow for its housekeepers and determined that scheduling was inconsistent and involved too much retracing of steps to collect trash, remove it to the trash room, and then go back to finish cleaning the room. Staffing schedules were adjusted to ensure consistent coverage and a dedicated staff person was assigned specifically to perform frequent, repetitive tasks such as pulling trash and linen.
- Scripting Staff Communication: To improve engagement by the housekeeping staff, the unit housekeeper visits each new admission. Staff were given training and a script of how to greet patients and orient them to the room. Additionally, non-verbal cues, such as a "while you were out" card, pillow bags, toilet seat band, and equipment status tags have been added to alert both patients and staff that the room has recently been cleaned.

The next phase of this project will be to start a new campaign for Harbor to "Keep our House Clean" with signs and banners reminding staff that everyone plays a role in maintaining a clean environment for patients and visitors. Historically, Harbor's H-CAHPS cleanliness score has hovered around the mid-fiftieth percentile. The first two months of these efforts has resulted in a jump in the hospital's H-CAHPS cleanliness score to over 60%. We expect further improvement over time.

Improving Communication with Nurses at LAC+USC Medical Center (LAC+USC): LAC+USC has recently launched several initiatives aimed at improving the communication between patients and nurses. These include:

- Creating scripts for nurses to remind patients that they may receive a survey at home and that they are encouraged to complete it.
- Providing customer service training to hospital nursing staff.
    - Using widely utilized frameworks that have been shown to improve communication, de-escalate complaints, and enhance customer service; these include: AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank You)
    - HEAT (Hear the patient, Empathize with their situation, Apologize for the events that led to their frustration, Take action to make things right)
- Empowering patients to take an active role in their care:
    - Asking patients to repeat back information to ensure they understand the information shared by the clinical team

  - Creating patient educational videos that teach patients about equipment used in their unit
  - Using the Bedside Shift Report which gives patients the opportunity to have a voice in their own care and to correct any errors during the handoff from the outgoing to the incoming nurse
  - Purchasing customized whiteboards within medical-surgical rooms to share information pertinent to a patient's admission, including contact information for their nurse and clinical team
- Supporting direct, intentional nurse-patient communication tools and tactics:
  - "Sit for a bit", encouraging nurses to sit, rather than stand, whenever they're interacting with patients
  - Connection Rounds where the nurse discovers one new thing per shift about one of their patients on a personal level
  - Daily Purposeful Rounding and Weekly Leadership Rounds to speak with patients and assess the environment

Improving the Hospital Environment (Noise Reduction) at Olive View-UCLA Medical Center (OV-UCLA)*:* The Patient Experience Committee at Olive-View identified noise reduction as the highest priority H-CAHPS metric for 2016. To help reduce noise levels on the inpatient units, the following initiatives were piloted in medical-surgical unit 5A:

- Change of shift reports take place at the end of hallways away from patient rooms instead of at the nursing station
- At 10 p.m., an overhead page announces quiet time. Nursing attendant staff put on quiet campaign vests and go room by room asking patients if they would like their door closed. These staff members also offer patients a comfort kit, consisting of an eye mask, lip balm, and ear plugs.
- Cleaning and maintenance efforts do not start before 6 a.m.
- Noisy linen and food tray carts have been replaced.
- Hospital overhead paging logs are reviewed to identify and eliminate unnecessary/inappropriate pages.

The pilot demonstrated good results. In the first quarter of 2016, 35% of unit 5A patients who responded to the H-CAHPS survey indicated that the area around their room was always quiet at night; this improved to 59% by the third quarter of 2016. OVMC is now in the process of expanding the successful initiatives implemented in unit 5A to all the other inpatient units and anticipates seeing an improvement in associated H-CAHPS scores hospital-wide in the coming months.

Improving Pain Management at Rancho Los Amigos National Rehabilitation Center (RLANRC)*:* The population at RLANRC has a high percentage of chronic pain, particularly patients with a spinal cord injury. Rancho has implemented several initiatives to ensure patients get the support they need in dealing with pain during their inpatient stay. A large focus has been

around education of the dangers of opioids. Patients on opioids and who are not diagnosed with cancer or have had a recent surgical procedure are flagged for secondary review. This review includes several components:

- Patient counseling on the dangers of long-term opioid use, tapering, the use of alternative pain control modalities (e.g. exercise, heat and cold modalities, psychological counseling, lifestyle redesign, meditation, physical and occupational therapy) and
- Provider-to-provider peer discussion on appropriate use of opioids and tapering of medication.

These interventions have helped adjust patient expectations and experiences around pain control and have enhanced the overall scores on this measure from 68.8% reporting that their pain was always well controlled in January 2016 to 75% of patients reported that their pain was always well controlled in June 2016.

DHS' primary clinics, which are the focus of the CG-CAHPS survey, also have a variety of initiatives ongoing to help improve overall service levels, patient experience, and patient satisfaction levels. A few of these initiatives are included below:

- Customer service training: Through DHS' partnership with WERC, over 8,700 employees at DHS have received customer service training. Feedback from the training has been very positive. DHS continues to work in partnership with organized labor on future phases of our customer service training programs and other activities that engage frontline staff to improve patient experience, including through the expanded use of Care Improvement Teams, team huddles, and other performance improvement structures.
- "Happy or Not": DHS is planning to initiate a pilot of the "Happy or Not" kiosk, made possible with funds obtained through the CHP Transition Safety Net Support Agreement with LA Care. These kiosks provide a quick and easy way to obtain real-time feedback from patients on specific changes made in particular aspects of the clinic. DHS is planning for a January 2017 pilot at Roybal Comprehensive Health Center. If successful, the kiosks will be expanded system-wide.
- Call Center capabilities: As mentioned earlier, scheduling, registration, and financial screening activities are being streamlined and organized under a facility-based Patient Access Center. With the pending implementation of VOIP technology and standardized call center software system-wide, DHS patients will have improved access to front-office staff when calling to seek care.
- Nurse Advice Line: DHS is in the process of planning for the implementation of a system-wide nurse advice line which will improve patient access to after-hours advice and appointment scheduling.
- IT tools: Refinements to primary care ORCHID workflows, implementation of Empaneled Life Management (ELM), and other IT tools will help providers deliver a higher level of care to patients, impacting their overall experience at DHS clinics.

- Non-traditional encounters: With a focus on primary care, DHS is working to increase access, patient experience, and staff experience through greater use of non-traditional visits (e.g., group visits, telephone consultations), as well as through greater use of non-provider staff, such as nurses and clinical pharmacists.

Finally, as with HEDIS, DHS' 5-year PRIME plan overlaps to a small degree with patient satisfaction survey tools: specifically DHS' plan includes one CG-CAHPS measure and one H-CAHPS measure. As such, DHS has an additional incentive to improve performance on these two measures in particular. Additional information is provided on PRIME below.

**Public Hospital Redesign and Incentives in Medi-Cal (PRIME)**

DHS has completed the first year of the five-year PRIME program, included as part of the Medi-Cal 2020 waiver. PRIME is an immense opportunity to serve our patients by prioritizing high impact patient care improvements and obtaining critical federal and state funding for our services. Similar to the importance of DSRIP in the last waiver, PRIME is a key component of this new waiver.

There are dozens of improvement projects in the PRIME program across three large domains – Outpatient Delivery System Transformation and Prevention, High Risk or High Cost Populations and Resource Utilization Efficiency. These projects make a meaningful difference in the health of our patients in areas such as cancer screening, tobacco cessation, medication use, inpatient and maternity care, specialty care, palliative care, chronic disease management, obesity and primary care. Our approach has been to engage each of our facilities in addressing the performance improvement projects with our entire population of patients in mind.

The first year of PRIME (DY11) establishes baseline data from which we are expected to show incremental improvement over the term of the project. We were successful in submitting a complete report on September 30th, 2016 to draw down the full amount of PRIME DY11 dollars. In year two of the project ending June 30, 2017 (DY12), a significant number of the PRIME projects become "pay for performance". DHS is currently addressing each of the areas where we need to improve on our baseline performance to achieve success in obtaining DY12 dollars. The remainder of the PRIME projects are in a "Pay for Reporting" during DY12. A summary of the PRIME projects and our first year performance is included in Appendix III.

To achieve PRIME goals, DHS has established 14 workgroups focused on one or more related PRIME metrics, each of which is led by a DHS clinician with deep expertise in the subject matter area. Each of these clinical leads has developed a detailed plan for how it will tackle each of the PRIME measures for which it is responsible. Examples of initiatives include:

1. Bringing the California Smokers' Helpline (1-800-NO-BUTTS) onto eConsult (July, 2016) to improve our performance in connecting smokers with counseling resources.

2. Establishing multidisciplinary ambulatory palliative care teams at our three acute care hospitals
3. Building and implementing new ORCHID-based tools that help our providers ensure that adult patients are getting their necessary cancer screening and children their nutrition and physical education counseling.

In addition to the project specific initiatives, DHS is also in the process of modifying ORCHID workflows, templates and reports which will allow us to standardize key procedures and document clearly the services we are providing. DHS is also designing registries and analytic tools in ELM, DHS' new population health registry and empanelment tool. During this build, we have ensured that PRIME-related projects are supported and prioritized.

We are enthusiastic about the PRIME program and are convinced that in achieving success in PRIME, we are investing in building a better health care system for all of our patients. We will continue to apprise you of new developments are they arise. If you have any questions or require additional information, please contact Dr. Christina Ghaly, Chief Operating Officer, at (213) 240-7787.

MHK:CG:rm

Attachments

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

# HEDIS Administrative Rates

Attachment 1

| | HEDIS Measures | PRIME Measures | LA Care 2015 DHS Results (%) (Measurement Period: 1/1/15-12/31/15 Claims received through: 1/1/16 ) | LA Care 2014 DHS Results (%) (Measurement Period: 1/1/14-12/31/14 Claims received through 6/12/15 ) | Health Net 2015 DHS Results (%) (Measurement Period: 1/1/15-12/31/15; Claims received through 2/29/16) | Health Net 2014 DHS Results (%) (Measurement Period: 1/1/14-12/31/14; Claims received through 7/16/15) | Minimum Performance Level (MPL) (%) | High Performance level (HPL) (%) |
|---|---|---|---|---|---|---|---|---|
| **Auto Assignment Measures** | Childhood Immunization Status - Combo 3 (CIS) | No | 54 | 30 | 50 | 54 | 67 | 81 |
| | Controlling High Blood Pressure (CBP) | Similar | *0 | *0 | *0 | *0 | 49 | 70 |
| | Cervical Cancer Screening (CCS) | Yes | 32 | 50 | 23 | 35 | 54 | 76 |
| | Comprehensive Diabetes Care (CDC) - HbA1c Screening | Yes | 84 | 84 | 77 | 85 | 80 | 92 |
| | Comprehensive Diabetes Care (CDC) - HbA1c Control (<8.0%) | Similar | 40 | 39 | 40 | 43 | 38 | 59 |
| | Comprehensive Diabetes Care (CDC) - Eye Exams | No | 30 | 15 | 43 | 41 | 46 | 68 |
| | Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care | Yes | 37 | 38 | 20 | 23 | 78 | 93 |
| | Prenatal and Postpartum Care (PPC) - Postpartum Care | Yes | 27 | 36 | 30 | 29 | 56 | 74 |
| | Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life (W34) | No | 54 | 64 | 40 | 58 | 66 | 83 |
| **Additional HEDIS Measures** | Adolescent Well-Care Visits (AWC) | No | NA | NA | NA | NA | NA | NA |
| | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) | Yes | 70 | 66 | 39 | 38 | 20 | 39 |
| | Annual Monitoring for Patients on Persistent Medications (MPM) - ACE Inhibitors or ARBs | Yes | 88 | 88 | 85 | 91 | 86 | 92 |
| | Annual Monitoring for Patients on Persistent Medications (MPM) - Digoxin | Yes | 39 | 30 | 44 | 27 | 89 | 96 |
| | Annual Monitoring for Patients on Persistent Medications (MPM) - Diuretics | Yes | 88 | 87 | 85 | 90 | 86 | 92 |
| | Medication Management for People with Asthma (MMA) - 50% of Treatment Period | No | NA | NA | 56 | NR | 48 | 67 |
| | Medication Management for People with Asthma (MMA) - 75% of Treatment Period | No | NA | NA | 32 | NR | 25 | 43 |
| | Colorectal Cancer Screening (COL) | Yes | 31 | 19 | NA | NA | NA | NA |
| | Breast Cancer Screening (BCS) | Yes | 58 | 59 | NA | 48 | 47 | 63 |
| | Chlamydia Screening in Women (CHL) | No | 52 | 44 | NA | NA | NA | NA |
| | Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy | No | 90 | 85 | NA | NA | NA | NA |
| | Immunizations for Adolescents (IMA) | No | 65 | 57 | 69 | 69 | 62 | 86 |
| | Appropriate Testing for Children with Pharyngitis (CWP) | No | 37 | 12 | NA | NA | NA | NA |
| | Antidepressant Medical Management (AMM) - Acute Phase | No | 57 | 47 | NA | NA | NA | NA |
| | Antidepressant Medical Management (AMM) - Continuation Phase | No | 48 | 50 | NA | NA | NA | NA |
| | Use of Imaging Studies for Low Back Pain | No | 28 | 26 | 68 | 77 | 72 | 84 |
| | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI | No | 14 | 10 | 34 | 48 | 42 | 82 |
| | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition | Yes | 6 | 10 | 38 | 50 | 50 | 77 |
| | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity | Yes | 3 | 2 | 10 | 8 | 42 | 70 |

NR: Rates are not produced for measures with fewer than 30 members in the denominator.

*Hybrid measures collected using Medical Record Review.

NA: Rates are not avaialble from Health Plans.

MPL: represents the national Medicaid 25th percentiles; HPL: represents the national Medicaid 90th percentiles; based on HEDIS 2015 rates.

# H-CAHPS Data
# Discharge Dates from July 1, 2014 - June 30, 2015 and July 1, 2015 - June 30, 2016

Percent top box score[1]

| | LAC DHS | | Harbor | | LAC+USC | | Olive View | | Rancho | | CA Peer Group | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2014-2015 | 2015-2016 | 2014-2015 | 2015-2016 | 2014-2015 | 2015-2016 | 2014-2015 | 2015-2016 | 2014-2015 | 2015-2016 | 2014-2015 | 2015-2016 |
| **Hospital Rating** | 75.6 | 74.8 | 66.6 | 68.3 | 77.6 | 77.9 | 74.7 | 75.4 | 83.6 | 81.2 | 70.8 | 71.3 |
| **Communication With Nurses** | 70.6 | 71.5 | 68.0 | 69.2 | 67.7 | 70.6 | 72.3 | 72.8 | 75.7 | 75.8 | 75.6 | 76.4 |
| **Response of Hosp Staff** | 59.4 | 59.9 | 57.6 | 58.3 | 60.6 | 61.0 | 56.9 | 57.7 | 63.1 | 64.7 | 62.8 | 63.0 |
| **Communication with Doctors** | 79.9 | 80.5 | 79.7 | 78.7 | 77.6 | 79.1 | 80.0 | 83.1 | 85.1 | 80.7 | 79.0 | 79.5 |
| **Hospital Environment** | 59.0 | 57.1 | 50.3 | 47.6 | 65.3 | 64.4 | 54.2 | 56.7 | 65.7 | 61.8 | 61.6 | 62.4 |
| **Pain Management** | 67.7 | 68.2 | 63.7 | 62.6 | 67.3 | 68.7 | 69.7 | 70.6 | 68.3 | 74.7 | 70.4 | 70.3 |
| **Communication About Meds** | 63.3 | 63.8 | 62.4 | 61.5 | 62.0 | 63.2 | 63.3 | 65.1 | 67.5 | 67.4 | 62.1 | 62.4 |
| **Discharge Information** | 83.1 | 87.4 | 79.4 | 85.4 | 81.5 | 87.4 | 84.2 | 88.1 | 87.6 | 90.0 | 85.4 | 85.5 |
| **Care Transitions** | 55.5 | 56.3 | 50.3 | 53.1 | 53.7 | 55.6 | 56.2 | 57.5 | 62.9 | 62.2 | 51.5 | 52.2 |

1. All domains report top box score on a five point scale with the exception of Hospital Rating which reports the top two box score on a ten point scale.

Source: Press Ganey Improvement Portal,
November 8, 2016

# CG-CAHPS Data, Visit Dates from July 1, 2014 - June 30, 2015 and July 1, 2015- June 30, 2016

**July 1, 2014 - June 30, 2015**

Percentile Rank based on all sites (n=16,106)

Note: All domains report top box score on a five point scale with the exception of Global Provider Rating which reports the top two box score on a ten point scale.

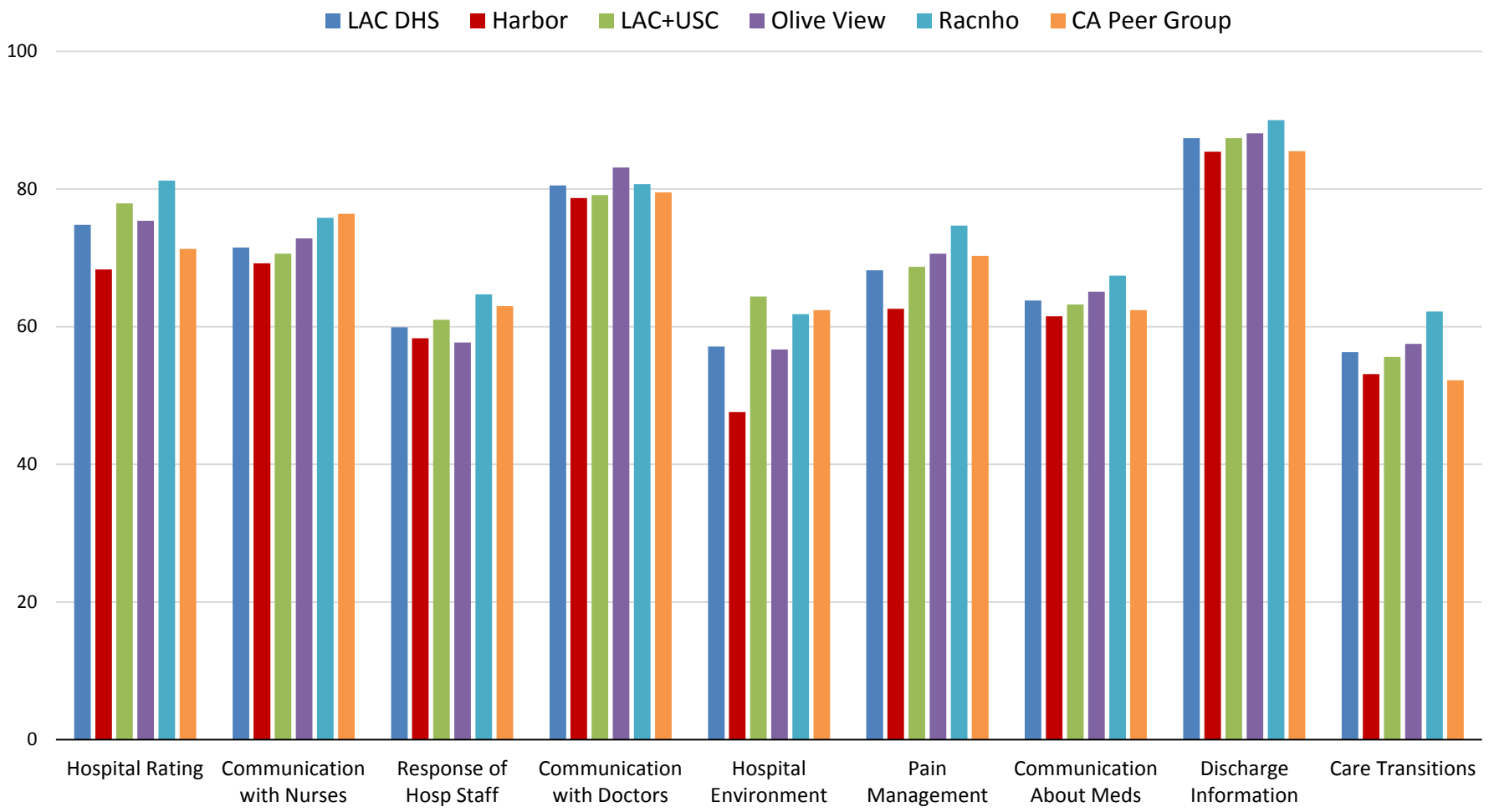
| | **GLOBAL** Provider Rating (9 -10) | | **ACCESS TO CARE Domain** Top Box value = 'Always' | | **TEST RESULTS** Top Box value = 'Yes' | | **PHYSICIAN COMM QUALITY Domain** Top Box value = 'Yes definitely' | | **OFFICE STAFF QUALITY Domain** Top Box value = 'Yes definitely' | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Percentile Rank | | Percentile Rank | | Percentile Rank | | Rank | | Rank |
| | **DHS Facility** | All Sites Average=84.2 | **DHS Facility** | All Sites Average = 63.8 | **DHS Facility** | All Sites Average = 80.3 | **DHS Facility** | All Sites average = 92.1 | **DHS Facility** | All Sites Average = 92.0 |
| LAC DHS | **59.9** | 1 | **34.8** | 1 | **55.7** | 4 | **76.0** | 1 | **73.5** | 1 |
| ACN | **57.7** | 1 | **34.4** | 1 | **54.3** | 3 | **73.4** | 1 | **73.6** | 1 |
| MLK+Dollarhide | **63.1** | 2 | **39.0** | 3 | **64.9** | 11 | **78.2** | 1 | **69.4** | 1 |
| Harbor | **60.9** | 2 | **35.9** | 2 | **56.8** | 5 | **79.8** | 2 | **70.0** | 1 |
| Rancho | **64.7** | 3 | **33.5** | 1 | **60.1** | 7 | **77.5** | 1 | **76.8** | 2 |
| LAC+USC | **63.7** | 2 | **36.1** | 2 | **52.7** | 3 | **79.3** | 2 | **72.8** | 1 |
| Olive View | **61.3** | 2 | **31.4** | 1 | **59.9** | 6 | **79.9** | 2 | **78.7** | 3 |

**July 1, 2015 - June 30, 2016**

Percentile Rank based on all sites (n=18,149)

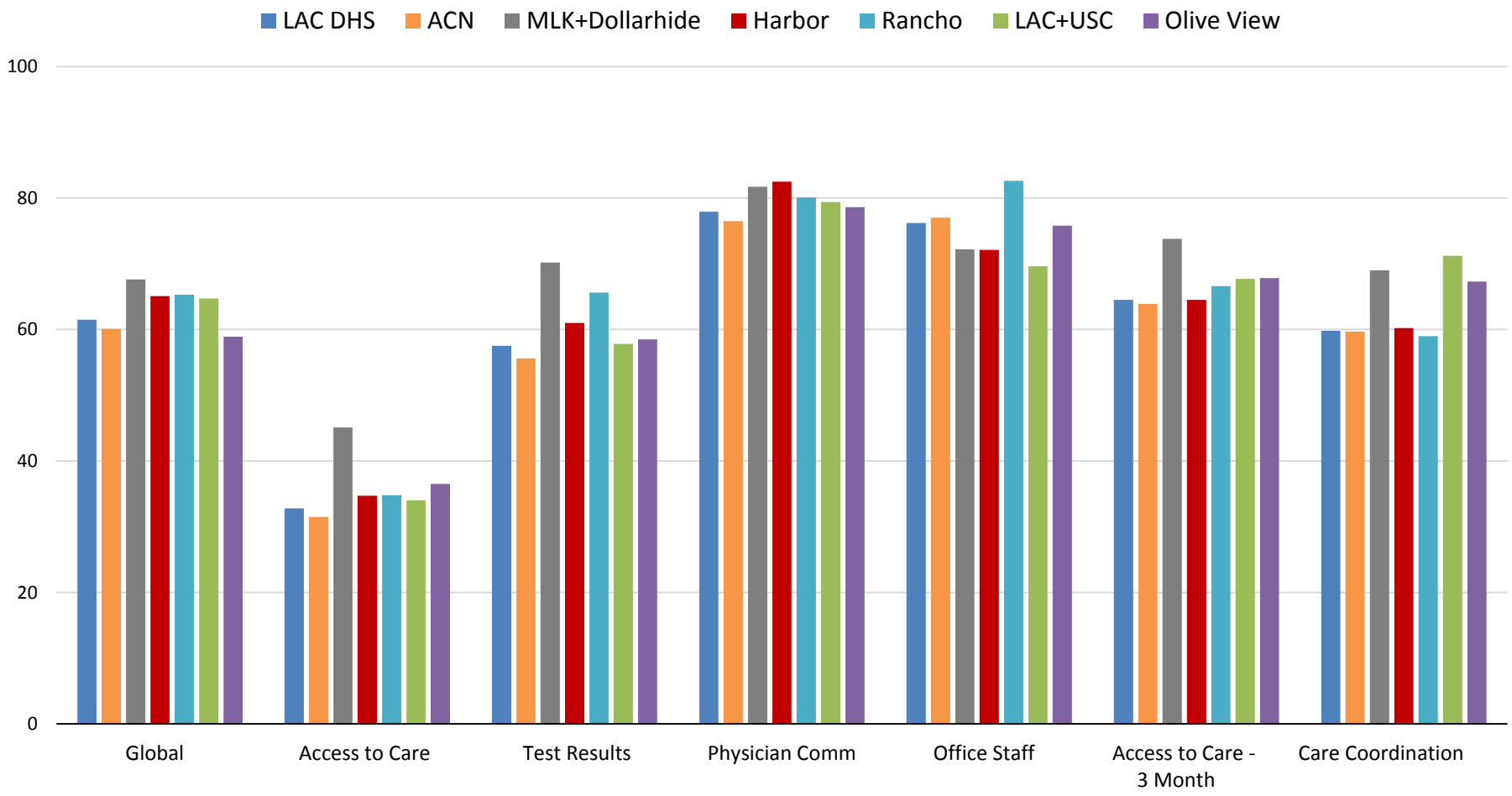
| | GLOBAL Provider Rating (9 -10) | | ACCESS TO CARE Domain Top Box value = 'Always' | | TEST RESULTS Top Box value = 'Yes' | | PHYSICIAN COMM QUALITY Domain Top Box value = 'Yes definitely' | | OFFICE STAFF QUALITY Domain Top Box value = 'Yes definitely' | | ACCESS TO CARE 3 MONTH Domain Top Box value='Always' | | CARE COORDINATION Top Box value = 'Always/Yes' | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | DHS Facility | Percentile Rank All Sites Average=85.2 | DHS Facility | Percentile Rank All Sites Average = 61.8 | DHS Facility | Percentile Rank All Sites Average = 80.4 | DHS Facility | Percentile Rank All Sites average = 92.4 | DHS Facility | Percentile Rank All Sites Average = 92.6 | DHS Facility | Percentile Rank All Sites Average = 79.9 | DHS Facility | Percentile Rank All Sites Average = 74.1 |
| LAC DHS | **61.5** | 1 | **32.8** | 2 | **57.5** | 5 | **77.9** | 1 | **76.2** | 1 | **64.5** | 6 | **59.8** | 4 |
| ACN | **60.1** | 1 | **31.5** | 2 | **55.6** | 4 | **76.5** | 1 | **77.0** | 2 | **63.9** | 6 | **59.7** | 3 |
| MLK+Dollarhide | **67.6** | 3 | **45.1** | 11 | **70.2** | 19 | **81.7** | 3 | **72.2** | 1 | **73.8** | 25 | **69.0** | 20 |
| Harbor | **65.1** | 2 | **34.7** | 3 | **61.0** | 7 | **82.5** | 3 | **72.1** | 1 | **64.5** | 6 | **60.2** | 4 |
| Rancho | **65.3** | 2 | **34.8** | 3 | **65.6** | 12 | **80.1** | 2 | **82.6** | 5 | **66.6** | 9 | **59.0** | 3 |
| LAC+USC | **64.7** | 2 | **34.0** | 2 | **57.8** | 5 | **79.4** | 2 | **69.6** | 1 | **67.7** | 11 | **71.2** | 29 |
| Olive View | **58.9** | 1 | **36.5** | 6 | **58.5** | 7 | **78.6** | 1 | **75.8** | 1 | **67.8** | 11 | **67.3** | 15 |

# H-CAHPS
## Percent Top Box Score[1]
## FY 2015-2016




1. All domains report top box score on a five point scale with the exception of Hospital Rating which reports the top two box score on a ten point scale.

# CG-CAHPS
## Percent Top Box Score[1]
## FY 2015-2016




1. All domains report top box score on a five point scale with the exception of Global Provider Rating which reports the top two box score on a ten point scale.

# PRIME Project Update - as of September 30th, 2016

| Domain and Project Title | PRIME ID# | Metric Title | Brief Description | Pay for Reporting (P4R) / Pay for Performance (P4P) status: Demonstration Year (DY) 11 | Demonstration Year 12 | Demonstration Year 13 | Demonstration Year 14 | Demonstration Year 15 | Minimum Benchmark Level | 90th percentile | DHS DY 11 Baseline (Pending DHCS Clinical Review) | DY 12 Target | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.1 Integration of Behavioral Health and Primary Care** | | | | | | | | | | | | | |
| | 1.1.1.a | Alcohol and Drug Misuse (SBIRT) | Standardized screening for alcohol and drug misuse | R | R | R | P | P | | 12 | **3.17** | reporting only | |
| | 1.1.2 | Care coordinator assignment | Assignment of care coordinator to each primary care patient | R | R | P | P | P | | | **0.00** | reporting only | |
| | 1.1.3.d | Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) | Patients with poorly controlled or unmonitored diabetes | R | P | P | P | P | 49.89 | 29.68 | **29.34** | Maintain | Lower is better |
| | 1.1.4 | Depression Remission at 12 Months CMS159v4 | Depressed patients who improve over a 12 month timeframe | R | R | P | P | P | | | **28.57** | reporting only | |
| | 1.1.5.f | Screening for Clinical Depression and follow-up | Percentage of patients receiving standardized screening for depression with action taken if screen is positive | R | R | P | P | P | 10.21 | 78.86 | **84.35** | reporting only | |
| | 1.1.6.t | Tobacco Assessment and Counseling | Percentage of patients screened for tobacco use and receive intervention if screen is positive | R | P | P | P | P | 72.37 | 95.79 | **70.57** | 73.09 | |
| **1.2 Ambulatory Care Redesign: Primary Care** | | | | | | | | | | | | | |
| | 1.2.1.a | Alcohol and Drug Misuse (SBIRT) | Standardized Screening for Alcohol and Drug Misuse | R | R | R | P | P | | 12 | **3.17** | reporting only | |
| | 1.2.10 | REAL and/or SO/GI disparity reduction | Reduction of a disparity with regards to race, ethnicity, language, sexual orientation or gender identity. | | | P | P | P | | | **NA** | reporting only | This project begins in July, 2018 |
| | 1.2.11 | REAL data completeness | Complete demographic data recorded in all REAL categories | R | P | P | P | P | | | **0.00** | reporting only | |
| | 1.2.12.f | Screening for Clinical Depression and follow-up | Percentage of patients receiving standardized screening for depression with action taken if screen is positive | R | R | P | P | P | 10.21 | 78.86 | **84.35** | reporting only | |
| | 1.2.13 | SO/GI data completeness | Patients either have documented sexual orientation and gender identity OR declined to state. | | R | P | P | P | | | **NA** | reporting only | |
| | 1.2.14.t | Tobacco Assessment and Counseling | Percentage of patients screened for tobacco use and receive intervention if screen is positive | R | P | P | P | P | 72.37 | 95.79 | **70.57** | 73.09 | |
| | 1.2.2 | CG-CAHPS: Provider Rating | Patients giving a score of "9 or 10" in the Provider Rating question on CG-CAHPS survey | R | P | P | P | P | 61.75 | 70.29 | **60.91** | 61.85 | |
| | 1.2.3.c | Colorectal Cancer Screening | Patients 50-75 years of age receiving appropriate colon cancer screening. | R | P | P | P | P | 59.85 | 79.17 | **62.22** | 63.92 | |
| | 1.2.4.d | Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) | Patients with poorly controlled or unmonitored diabetes | R | P | P | P | P | 49.89 | 29.68 | **29.34** | Maintain | Lower is better |
| | 1.2.5.b | Controlling Blood Pressure | Percentage of patients with appropriately controlled blood pressure. | R | P | P | P | P | 49.88 | 70.32 | **66.16** | 66.57 | |
| | 1.2.6 | Documented REAL and/or SOGI disparity reduction plan | Project develped to reduce a disparity with regards to race, ethnicity, language, sexual orientation or gender identity. | | R | | | | | | **NA** | reporting only | |
| | 1.2.7.i | Ischemic Vascular Disease (IVD): Use of Aspirin /Antithrombotic | Patients with ischemic vascular disease who receive antithrombotic therapy. | R | P | P | P | P | 68.08 | 92.86 | **75.90** | 77.59 | |
| | 1.2.8 | Prevention Quality Overall Composite #90 | Prevention of hospitalizations for a select group of preventable conditions. | R | R | P | P | P | | | **3.12** | reporting only | |
| | 1.2.9 | Primary Care Redesign metrics stratified by REAL/SOGI | PRIME 1.2 projects stratified by REAL/SOGI data - intended to identify disparity for reduction - 1.2.6 | | R | | | | | | **NA** | reporting only | |
| **1.3 Ambulatory Care Redesign: Specialty Care** | | | | | | | | | | | | | |
| | 1.3.1 | Closing the referral loop: receipt of specialist report | Specialist report received by provider who requested the specialty expertise | R | R | P | P | P | 0 | 83.2 | **87.61** | reporting only | |
| | 1.3.2 | DHCS All-Cause Readmissions – Statewide Collaborative QIP measure (Measure Specs -rationale in Appendix A & B) | Count of 30 day readmissions | R | P | P | P | P | 17.70 | 13.18 | **12.93** | Maintain | Lower is better |
| | 1.3.3 | Influenza Immunization | patients receiving influenza immunization | R | R | P | P | P | | | **36.33** | reporting only | |
| | 1.3.4 | Post procedure ED visits | patients going to ED for complications due from a procedure performed in the prior 7 days | R | R | R | P | P | | | **1.73** | reporting only | Lower is better |

**DY 11 PRIME Metric Results**



| | A | D | G | H | I | J | K | L | M | Q | R | Y | AB | AF |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2 | Domain and Project Title | PRIME ID# | Metric Title | Brief Description | Demonstration Year (DY) 11 | Demonstration Year 12 | Demonstration Year 13 | Demonstration Year 14 | Demonstration Year 15 | Minimum Benchmark Level | 90th percentile | DHS DY 11 Baseline (Pending DHCS Clinical Review) | DY 12 Target | Comments |
| 30 | | 1.3.5 | Referral Reply Turnaround Rate | Percentage of replies within 4 calendar days to specialty care requests | R | R | R | P | P | | | **78.82** | reporting only | |
| 31 | | 1.3.6 | Specialty Care Touches: Specialty expertise requests managed via non-face to face specialty encounters | Percentage of specialty care requests that are managed without a face to face visit. | R | R | R | R | R | | | **23.01** | reporting only | |
| 32 | | 1.3.7 | Tobacco Assessment and Counseling | Percentage of patients screened for tobacco use and receive intervention if screen is positive | R | P | P | P | P | 72.37 | 95.79 | **77.73** | 79.53 | |
| 33 | **1.4 Patient Safety in the Ambulatory Setting** | | | | | | | | | | | | | |
| 34 | | 1.4.1 | Abnormal Results Follow-up - BIRADS | Percentage of patients who have appropriate and timely follow up for abnormal mammogram results | R | R | R | P | P | | | **56.04** | reporting only | |
| 35 | | 1.4.1 | Abnormal Results Follow-up - INR | Percentage of patients who have appropriate and timely follow up for abnormal INR results | R | R | R | P | P | | | **95.08** | reporting only | |
| 36 | | 1.4.1 | Abnormal Results Follow-up - K+ | Percentage of patients who have appropriate and timely follow up for abnormal potassium results | R | R | R | P | P | | | **95.20** | reporting only | |
| 37 | | 1.4.2 | Annual Monitoring for Patients on Persistent Medications | Percentage of patients on select chronic medications who have received appropriate annual laboratory testing. | R | P | P | P | P | 84.46 | 91.59 | **89.47** | 89.68 | |
| 38 | | 1.4.3 | INR Monitoring for Individuals on Warfarin | Percentage of Patients on warfarin who have had an INR performed within each 56 day interval | R | R | P | P | P | | | **41.13** | reporting only | |
| 39 | **1.6 Cancer Screening and Follow-Up** | | | | | | | | | | | | | |
| 40 | | 1.6.1 | BIRADS to Biopsy | Percentage of patients receiving a breast biopsy within 14 business days of of a BIRADS 4 or 5 result | R | R | R | R | R | | | **43.96** | reporting only | |
| 41 | | 1.6.2 | Breast Cancer Screening | Percentage of eligible patients receiving a screening mammogram | R | P | P | P | P | 51.59 | 71.41 | **61.30** | 62.31 | |
| 42 | | 1.6.3 | Cervical Cancer Screening | Percentage of eligible patients receiving cervical cancer screening | R | P | P | P | P | 54.33 | 73.08 | **34.24** | 54.33 | |
| 43 | | 1.6.4.c | Colorectal Cancer Screening | Patients 50-75 years of age receiving appropriate colon cancer screening. | R | P | P | P | P | 59.85 | 79.17 | **62.22** | 63.92 | |
| 44 | | 1.6.5 | Receipt of appropriate follow-up for abnormal CRC screening | Percentage of patients receiving a colonoscopy within 6 months of a positive stool screening test. | R | R | R | P | P | | | **31.48** | reporting only | |
| 45 | **1.7 Obesity Prevention and Healthier Foods Initiative** | | | | | | | | | | | | | |
| 46 | | 1.7.1 | BMI Screening and Follow-up | Patients with documented BMI and if abnormal, appropriate follow up is documented. | R | P | P | P | P | 40.09 | 87.66 | **36.17** | 41.32 | |
| 47 | | 1.7.2 | Partnership for a Healthier America's Hospital Health Food Initiative external food service verification | Implementation of the Healthier America Hospital Food Initiative. | R | P | P | P | P | | | **Yes** | 2/8 met | |
| 48 | | 1.7.3 | Weight Assess & Counsel for Child/Adolescents - BMI | Percentage of pediatric patients with BMI percentile | R | P | P | P | P | 51.27 | 85.61 | **21.83** | 51.27 | |
| 49 | | 1.7.3 | Weight Assess & Counsel for Child/Adolescents -Nut | Percentage of pediatric patients with documented counseling for nutrition | R | P | P | P | P | 51.98 | 79.56 | **4.55** | 51.98 | |
| 50 | | 1.7.3 | Weight Assess & Counsel for Child/Adolescents - Physical Activity | Percentage of pediatric patients with documented counseling for physical activity | R | P | P | P | P | 44.16 | 71.53 | **7.78** | 44.16 | |
| 51 | **2.1 Improvements in Perinatal Care** | | | | | | | | | | | | | |
| 52 | | 2.1.1 | Baby Friendly Hospital designation | Achieving Baby Friendly Hospital Designation | R | P | P | P | P | | | **3 of 3** | Maintain | |
| 53 | | 2.1.2 | Exclusive Breast Milk Feeding (PC-05) | Babies born in hospital who are fed only breast milk since birth. | R | P | P | P | P | 57.3 | 85.9 | **Statewide Collaborative** | | Baseline data expected December, 2016 |
| 54 | | 2.1.3 | OB Hemorrhage: Massive Transfusion | Percentage of women receiving more than 4 units of blood during a birth admission. | R | R | R | R | R | | | **Statewide Collaborative** | reporting only | Baseline data expected December, 2016 |
| 55 | | 2.1.4 | OB Hemorrhage: Total Products Transfused | Total number of blood products transfused during a birth admission. | R | R | R | R | R | | | **Statewide Collaborative** | reporting only | Baseline data expected December, 2016 |

**DY 11 PRIME Metric Results**



| | A | D | G | H | I | J | K | L | M | Q | R | Y | AB | AF |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2 | Domain and Project Title | PRIME ID# | Metric Title | Brief Description | Demonstration Year (DY) 11 | Demonstration Year 12 | Demonstration Year 13 | Demonstration Year 14 | Demonstration Year 15 | Minimum Benchmark Level | 90th percentile | DHS DY 11 Baseline (Pending DHCS Clinical Review) | DY 12 Target | Comments |
| 56 | | 2.1.5 | PC-02 Cesarean Section | Percentage of live births by cesarean section | R | P | P | P | P | 28.5 | 18.5 | **Statewide Collaborative** | | Lower is better. Baseline data expected December, 2016 |
| 57 | | 2.1.6 | Prenatal and Postpartum Care (Prenatal) | Percentage of patients with birth admission who received a first trimester prenatal visit or a prenatal visit within 42 days of enrollment/accountability | R | P | P | P | P | 77.44 | 91.73 | **51.02** | 77.44 | |
| 58 | | 2.1.6 | Prenatal and Postpartum Care (Postpartum) | Percentage of patients with birth admission who received a postpartum visit between 21-56 days after delivery | R | P | P | P | P | 55.47 | 72.43 | **33.65** | 55.47 | |
| 59 | | 2.1.7 | Severe Maternal Morbidity (SMM) per 100 women with obstetric hemorrhage | Rate of women with a birth admission who experienced severe maternal morbidity | R | R | R | R | R | | | **Statewide Collaborative** | reporting only | Lower is better, Baseline data expected December, 2016 |
| 60 | | 2.1.8 | Unexpected Newborn Complications | Rate of newborns experiencing complications | R | R | R | R | R | | | **Statewide Collaborative** | reporting only | Lower is better, Baseline data expected December, 2016 |
| 61 | | 2.1.9 | Hemorrhage Safety Bundle | Implementation of safety requirements with regards to Obstetric hemorrhage | R | P | P | P | P | | | **Done** | 50.00 | requires 8 of 16 requirements met in DY 12; in DY 11, DHS met 27 of 48 total (for the three DHS hospitals) |
| 62 | **2.2 Care Transitions: Integration of Post-Acute Care** | | | | | | | | | | | | | |
| 63 | | 2.2.1 | DHCS All-Cause Readmissions – Statewide Collaborative QIP measure (Measure Specs -rationale in Appendix A & B) | Count of 30 day readmissions | R | P | P | P | P | 17.70 | 13.18 | **12.17** | Maintain | Lower is better |
| 64 | | 2.2.2 | H-CAHPS: Care Transition Metrics | Score for how well patients understood their care upon leaving hospital | R | P | P | P | P | 48 | 61 | **56.05** | 56.54 | |
| 65 | | 2.2.3 | Medication Reconciliation - 30 days | Percentage of patients with recent hospital admissions whose updated medication list is present in the outpatient medical record | R | R | P | P | P | | | **28.91** | reporting only | |
| 66 | | 2.2.4 | Reconciled Medication List Received by Discharged Patients | Percentage of inpatients receiving a reconciled medication list at time of hospital discharge. | R | R | P | P | P | | | **58.60** | reporting only | |
| 67 | | 2.2.5 | Timely Transmission of Transition Record | Percentage of inpatients for which a complete transition record was transmitted to the PCP within 24 hours of discharge | R | R | P | P | P | | | **0.00** | reporting only | |
| 68 | **2.3 Complex Care Management for High Risk Medicial Populations** | | | | | | | | | | | | | |
| 69 | | 2.3.1 | Care coordinator assignment | Assignment of care coordinator to each primary care patient | R | R | P | P | P | | | **0.00** | reporting only | |
| 70 | | 2.3.2 | Medication Reconciliation – 30 days | Patients with recent hospital admissions whose updated medication list is present in the outpatient medical record | R | R | P | P | P | | | **25.46** | reporting only | |
| 71 | | 2.3.3 | Prevention Quality Overall Composite #90 | Prevention of hospitalizations for a select group of preventable conditions. | R | R | P | P | P | | | **10.26** | reporting only | |
| 72 | | 2.3.4 | Timely Transmission of Transition Record | Percentage of inpatients for which a complete transition record was transmitted to the PCP within 24 hours of discharge | R | R | P | P | P | | | **0.00** | reporting only | |
| 73 | **2.5 Transition to Integrated Care: Post Incarceration** | | | | | | | | | | | | | |
| 74 | | 2.5.1 | Alcohol and Drug Misuse (SBIRT) | Standardized Screening for Alcohol and Drug Misuse | R | R | R | P | P | | 12 | **4.31** | reporting only | |
| 75 | | 2.5.2 | Controlling Blood Pressure | Percentage of patients with appropriately controlled blood pressure. | R | P | P | P | P | 49.88 | 70.32 | **32.00** | 49.88 | |
| 76 | | 2.5.3 | Prevention Quality Overall Composite #90 | Prevention of hospitalizations for a select group of preventable conditions. | R | R | P | P | P | | | **7.64** | reporting only | |
| 77 | | 2.5.4 | Screening for Clinical Depression and follow-up | Percentage of patients receiving standardized screening for depression with action taken if screen is positive | R | R | P | P | P | 10.21 | 78.86 | **70.97** | reporting only | |
| 78 | | 2.5.5 | Tobacco Assessment and Counseling | Percentage of patients screened for tobacco use and receive intervention if screen is positive | R | P | P | P | P | 72.37 | 95.79 | **58.73** | 72.37 | |
| 79 | **2.7 Comprehensive Advanced Illness Planning and Care** | | | | | | | | | | | | | |

**DY 11 PRIME Metric Results**



| | A | D | G | H | I | J | K | L | M | Q | R | Y | AB | AF |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2 | Domain and Project Title | PRIME ID# | Metric Title | Brief Description | Demonstration Year (DY) 11 | Demonstration Year 12 | Demonstration Year 13 | Demonstration Year 14 | Demonstration Year 15 | Minimum Benchmark Level | 90th percentile | DHS DY 11 Baseline (Pending DHCS Clinical Review) | DY 12 Target | Comments |
| 80 | | 2.7.1 | Advance Care Plan | Percentage of patients who either have an advance care plan/surrogate documented in chart or have documentation that this was discussed. | R | R | P | P | P | | | **97.48** | reporting only | |
| 81 | | 2.7.2 | Ambulatory Palliative Team Established | Presence of a multidisciplinary palliative care team | R | P | | | | | | **No** | Yes | |
| 82 | | 2.7.3 | MWM#8 - Treatment Preferences (Inpatient) | Percentage of inpatients with documentation of life sustaining preferences | R | R | P | P | P | | | **36.00** | reporting only | |
| 83 | | 2.7.4 | MWM#8 - Treatment Preferences (Outpatient) | Percentage of outpatients with documentation of life sustaining preferences or that this was offered. | R | R | R | P | P | | | **55.56** | reporting only | |
| 84 | | 2.7.5 | Palliative care service offered at time of diagnosis of advanced illness | Percentage of patients with select advanced conditions who were offered palliative care services | R | R | P | P | P | | | **19.20** | reporting only | |
| 85 | | 2.7.6 | Proportion admitted to hospice for less than 3 days | Percentage of patients who died less than 3 days after admission to hospice. | R | R | P | P | P | | | **15.63** | reporting only | |
| 86 | **3.1 Antibiotic Stewardship** | | | | | | | | | | | | | |
| 87 | | 3.1.1 | Avoidance of antibiotic treatment in adults with acute bronchitis | Rate of patients given antibiotics within 3 days of a diagnosis of acute bronchitis | R | P | P | P | P | 22 | 40.38 | **46.78** | Maintain | inverted rate, higher is better |
| 88 | | 3.1.2 | Avoidance of Antibiotic Treatment with Low Colony Urinary Cultures | Percentage of inpatients given antibiotics for low colony count urine cultures | R | R | R | P | P | | | 41.12 | reporting only | Lower is better |
| 89 | | 3.1.3 | National Healthcare Safety Network (NHSN) Antimicrobial Use Measure | Period of time for which inpatients are exposed to select antibiotics | R | R | P | P | P | | | 0.19 | reporting only | |
| 90 | | 3.1.4 | Prophylactic antibiotics discontinued at time of surgical closure | Percentage of select surgical cases in which prophylactic antibiotics are not administered after surgical closure | R | R | R | P | P | | | **28.94** | reporting only | |
| 91 | | 3.1.5 | Reduction in Hospital Acquired Clostridium Difficile Infections | Rate of hospital onset C.Dif. | R | P | P | P | P | 1.115 | 0 | **0.778** | 0.700 | Lower is better |
| 92 | **3.3 Resource Stewardship: Therapies Involving High Cost Pharmaceuticals** | | | | | | | | | | | | | |
| 93 | | 3.3.1 | Adherence to Medications | Compliance measure for patients on high cost medications | R | R | R | P | P | | | **90.20** | reporting only | |
| 94 | | 3.3.2 | Documentation of Current Medications in the Medical Record | Percentage of patients with complete documentation of current medications and supplements in medical record | R | P | P | P | P | 50 | 100 | **46.09** | 51.48 | |
| 95 | | 3.3.3 | High-cost Pharmaceutical Ordering Protocols | Percentage of high cost medication prescriptions for which an ordering protocol was employed. | R | R | R | P | P | | | **58.82** | reporting only | |